MASSAGE THERAPY

Dr Mr
Full Name Mrs Ms Miss____ Birth Date _____ /____/ ______
dd / mm / yy

Address____

City _______________________ Province _______________ Postal Code _________________

Phone (res) (____) _____________ Phone (wk) (____) _________________Phone (cell) (____) _________________

Email ____

Employer _______________________________________ Occupation _____________________________________

Age _________________ Height _____________ Weight _____________

If under 18 name of responsible party____

Your major complaint or symptom is ____

Medications: _______________________________ Reason for taking: ___________________________________

Name of family Physician____

Who referred you or how did you hear about our clinic? (circle one and please specify name)

Family Member   Friend   Physician   Phone Book   ______________________________
name

Please answer the following questions by circling the appropriate answer. If Yes please explain

Have you had a professional massage before? NO YES____

Have you ever had surgery? NO YES____

Do you have any spinal problems? NO YES____

Are you pregnant? NO YES____

Do you wear contact lenses or dentures? NO YES____

Do you take an prescribed medications? NO YES____

Do you have chronic back pain? NO YES____

Do you have frequent headaches? NO YES____

Are you constantly tired? NO YES____

Do you have any heart problems? NO YES____

Do you have high blood pressure? NO YES____

Do you have varicose veins? NO YES____

Do you have any blood clots? NO YES____

Have you ever had cancer? NO YES____

Do you have arthritis? NO YES____

Have you suffered any acute injury/accident? NO YES____

Do you have pain which radiates down legs or arms? NO YES___________________________________

Do you suffer from tension? NO YES____

Do you have chronic diarrhea? NO YES____

Do you have chronic constipation? NO YES____

Do you smoke? If yes, how much per day? NO YES____

Do you have diabetes? NO YES____

Do you see a Chiropractor? If yes, name of doctor: ____

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I am also aware that the clinic requires a 24 hour cancellation notice for all massage appointments and that a fee of the full charge of the massage will be charged if less then 24 hours notice is given.

Signature of patient____ Date: __________________________________
(or parent/guardian)